

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4647

CERTIFICATE OF DEATH

04610

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				d. STREET ADDRESS Henderson			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Deane Middle Leroy Last Barcus				4. DATE OF DEATH Month 4/ Day 20 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/86	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timekeeper		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James T. Barcus				14. MOTHER'S MAIDEN NAME Emma Dean			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215 20 0864		17. INFORMANT Adelaide Barcus, wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT (THROMBOSIS) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) 10+ YEARS INTERVAL BETWEEN ONSET AND DEATH 5 DAYS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMPHYSEMA, PNEUMONIA, UREMIA							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Centerville				(County) MD		(State) MD	
21. I certify that I attended the deceased from SEPTEMBER 19, 59 , to 4/20/1960 , that I last saw the deceased alive on 4/20/1960 , and that death occurred at 5:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 105 CHESTERFIELD AVE. CENTREVILLE, MD. DATE SIGNED 4/21/60							
ACTUAL SIGNATURE J. Kent Young M.D.				DATE SIGNED 4/21/60			
PHYSICIAN'S NAME (Type) J. KENT YOUNG							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/23/60		22c. NAME OF CEMETERY OR CREMATORY Centerville		22d. LOCATION (City, town, or county) (State) Centerville MD	
23. FUNERAL DIRECTOR'S SIGNATURE Alan S. Lane				ADDRESS Chuck Hill		24a. REC'D BY REGISTRAR DATE APR 26 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1-1-1918

NAME OF DECEASED John Doe		SEX Male		AGE 45		DATE OF BIRTH Jan 1, 1873		PLACE OF BIRTH Maryland	
FATHER'S NAME John Doe		MOTHER'S NAME Jane Doe		DATE OF DEATH Jan 1, 1918		PLACE OF DEATH Maryland		CAUSE OF DEATH Heart Disease	
OCCUPATION Farmer		EDUCATION High School		MARRIED Yes		SINGLE No		WIDOWED No	
RELIGION Roman Catholic		COLOR White		HAIR Brown		EYES Blue		SKIN Fair	
PREVIOUS ILLNESS None		TREATMENT None		DIAGNOSIS Heart Disease		PROGNOSIS Fatal		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN Dr. John Doe		SIGNATURE OF WITNESS John Doe		SIGNATURE OF DECEASED John Doe		SIGNATURE OF NEXT OF KIN Jane Doe		SIGNATURE OF CLERK John Doe	
DATE Jan 1, 1918		TIME 10:00 AM		PLACE Maryland		COUNTY Baltimore		CITY Baltimore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4654

CERTIFICATE OF DEATH

64611

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETTERTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BETTERTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY MYRTLE BECK</u>		4. DATE OF DEATH Month Day Year <u>APRIL 14 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 19, 1889</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11c. BIRTHPLACE (State or foreign country) <u>BALTIMORE, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S. A.</u>	
13. FATHER'S NAME <u>PHILLIP M. PADGETT</u>		14. MOTHER'S MAIDEN NAME <u>ANNABELLE FLOWERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Wm HENRY BECK, BETTERTON</u>		Address <u>HUSBAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARDIO-RENAI HYPERTENSIVE DISEASE</u> 4 YRS (c) <u>CEREBRO-VASCULAR ACCIDENTS</u> 2 YEARS		INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV. 1955</u> , 19, to <u>APRIL 14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>APRIL 13</u> , 19 <u>60</u> , and that death occurred at <u>5:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>WORTON, Md</u> DATE SIGNED <u>4-14-60</u> ACTUAL SIGNATURE <u>Florence Deringer Joyce</u> M.D. <u>WORTON, Md</u> PHYSICIAN'S NAME (Type) <u>Florence Deringer Joyce</u> <u>Worton, Md.</u> <u>4/14/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-18-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEM. PK.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor M. Kennedy</u> ADDRESS <u>STILL POND, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 18 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

CERTIFICATE OF DEATH

442X

DECEASED'S NAME [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		RACE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]	
DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]	
ADDRESS OF DECEASED [Faint text]		ADDRESS OF PHYSICIAN [Faint text]		ADDRESS OF WITNESS [Faint text]	
CITY [Faint text]		COUNTY [Faint text]		STATE [Faint text]	
ZIP CODE [Faint text]		DECEASED'S SOCIAL SECURITY NUMBER [Faint text]		PHYSICIAN'S LICENSE NUMBER [Faint text]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4648

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 40 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
3. NAME OF DECEASED (Type or print) First Emma Middle Stradley Last Caldwell		4. DATE OF DEATH Month 4 Day 26 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/17/78
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		12. KIND OF BUSINESS OR INDUSTRY Delaware	
13. BIRTHPLACE (State or foreign country) U.S.A.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Benjamin Stradley		16. MOTHER'S MAIDEN NAME Emily Burris	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		18. SOCIAL SECURITY NO. (none)	
19. INFORMANT Mary L. Caldwell, daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.0 (c) 3 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-1 , 19 60 , to 4-26 , 19 60 , that I last saw the deceased alive on 4-25 , 19 60 , and that death occurred at 3:15 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE A.C. Dick M.D.		ADDRESS (Street, city or town, state) Chestertown, Md DATE SIGNED 4-26-60	
PHYSICIAN'S NAME (Type) A.C. Dick			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/60	
22c. NAME OF CEMETERY OR CREMATORY Galena Cemetery		22d. LOCATION (City, town, or county) (State) Galena Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chesterfield, Md.	
24a. REC'D BY REGISTRAR APR 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

1918

<p>1. Name of deceased John A. Smith</p>		<p>2. Date of death 1918</p>	
<p>3. Place of death Home</p>		<p>4. Cause of death Heart failure</p>	
<p>5. Age at death 65</p>		<p>6. Sex Male</p>	
<p>7. Race White</p>		<p>8. Marital status Married</p>	
<p>9. Occupation Teacher</p>		<p>10. Residence 123 Main St., City</p>	
<p>11. Signature of physician Dr. J. H. Brown</p>		<p>12. Signature of registrar John D. White</p>	
<p>13. Date of registration 1918</p>		<p>14. Place of registration City</p>	

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THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall (rural)</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Delaware</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linwood</u> d. STREET ADDRESS <u>14 Langhead Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Alexander Carrow</u>			4. DATE OF DEATH Month Day Year <u>April 11 1960</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>July 12 1905</u>		9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Arthur Carrow</u>				
14. MOTHER'S MAIDEN NAME <u>Elizabeth Mooney</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>180 03 2915</u>			17. INFORMANT Address <u>Mrs Helen Carrow, Chestertown Pa.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Unusual physical exertion sustained while fighting a field fire</u> (c) <u>Has a history of having had heart trouble and hypertension. Treated in Sacred Heart Hospital</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chestertown, Pa. for 5 days approximately 3 weeks ago.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) 		(County) 		(State) 			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Robert W. Farr</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Robert W. Farr</u>			DATE SIGNED <u>11 April, 1960</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lawncroft Cem.</u>			
22d. LOCATION (City, town, or county) <u>Boothwyn Del. Co. Penna.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>			ADDRESS <u>Chestertown, Md.</u>				
24a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4656

64615

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Near Rock Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha A. Harris</u>				4. DATE OF DEATH Month Day Year <u>Apr. 26, 1960</u> <u>19</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <u>X</u> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 28, 1899</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Clayton Rochester</u>				14. MOTHER'S MAIDEN NAME <u>Louise Banks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>215-26-4458</u>		17. INFORMANT <u>James Harris Rock Hall, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension - Cordis Vasculor</u> DUE TO (c) <u>Carcinoma of Cervix</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>April 1, 1960</u> to <u>April 26, 1960</u> that (I) (we) last saw the deceased alive at <u>April 26, 1960</u> and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Norbert C. Nitsch</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <u>4/27/60</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Norbert C. Nitsch</u>				22d. ADDRESS <u>Rock Hall, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/30/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sharptown Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>nr. Rock Hall, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walker</u>				ADDRESS <u>Chestertown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 29 1960</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles L. Knecht</u>			

CERTIFICATE OF DEATH

6030



10/10/10

10/10/10

10/10/10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4649

CERTIFICATE OF DEATH

4616

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 30 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville X				d. STREET ADDRESS /			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Cornelius Middle Jarvis Last Jarvis				4. DATE OF DEATH April Month 21 Day 19 Year 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1872	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Jarvis				14. MOTHER'S MAIDEN NAME Susan Pennington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-22-8412		INFORMANT Address Hospital records, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 30 days 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 5-6- 1959 , to April 21 , 1960 , that I last saw the deceased alive on April 20 , 1960 , and that death occurred at 4:55a. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 4-21-60							
ACTUAL SIGNATURE A.C. Dick		PHYSICIAN'S NAME (Type) A.C. Dick					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April, 24, 1960	22c. NAME OF CEMETERY OR CREMATORY Galena Cemetery		22d. LOCATION (City, town, or county) (State) Galena, Kent Co. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows		ADDRESS Millington, Md.		24a. REC'D BY REGISTRAR DATE APR 25 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Now

4650

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) o. STATE Maryland b. COUNTY Queen Annes ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown.		c. LENGTH OF STAY IN lb 45 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centerville 17x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent + Queen Anns Hosp.				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Miles		4. DATE OF DEATH Month April Day 2 Year 1960			
5. SEX male		6. COLOR OR RACE Negro		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH April 2, 1960	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 45 min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Houseo Miles		14. MOTHER'S MAIDEN NAME Dorothy A. Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Address Houseo Miles Centerville Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Adilexites (c) Pre maturely 24 weeks 25 min				INTERVAL BETWEEN ONSET AND DEATH 10 m	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1960, to April 2, 1960, that I last saw the deceased alive on April 2, 1960, and that death occurred at 12 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE C. R. Layton M.D. Centerville 4-2-60 PHYSICIAN'S NAME (Type) C. R. Layton Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr 2-1960		22c. NAME OF CEMETERY OR CREMATORY Chestnutfield	
				22d. LOCATION (City, town, or county) (State) Centerville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William B. ...		ADDRESS Centerville Md		24a. REC'D BY REGISTRAR DATE APR 4 '60	
				24b. REGISTRAR'S SIGNATURE ...	

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Items 8 & 9 Film G261 4/29/60 iwk									
Reg. Dist. No. 64618									
1. PLACE OF DEATH o. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond		c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1					
3. NAME OF DECEASED (Type or print) Jesse		First		Middle Mills		Last		4. DATE OF DEATH Month April Day 4 Year 19 60	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1901		9. AGE (In years last birthday) 59 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Del. State Roads		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214 30 8676		17. INFORMANT Hattie Cole		Address Still Pond, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic insufficiency known for one year 023X DUE TO Probable Syphilitic Aortitis known for one year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterial Hypertension, Congestive Failure 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Robert W. Farr, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 5, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/9/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemty		22d. LOCATION (City, town, or county) (State) Still Pond, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR APR 6 '60		24b. REGISTRAR'S SIGNATURE Clarence E. Kennedy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4658

CERTIFICATE OF DEATH

64610

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Betterton</u>				c. LENGTH OF STAY IN 1b <u>5 years</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Betterton</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>K.</u> Last <u>Motter</u>				4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 9, 1880</u>			
9. AGE (In years last birthday) yrs. <u>79</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Postmaster</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Mail</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>									
13. FATHER'S NAME <u>Isaac M. Motter</u>				14. MOTHER'S MAIDEN NAME <u>Serene Kunkel</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>I</u> Yes <u>WWI</u> None <u> </u>				16. SOCIAL SECURITY NO. <u> </u>					
17. INFORMANT <u>John M. Motter</u>				Address <u>Betterton, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Pulmonary Edema</u> DUE TO (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Infarct</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>8/10, 1955</u> , to <u>4/18, 1960</u> , that I last saw the deceased alive on <u>4/10, 1960</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>4-18-60</u>									
ACTUAL SIGNATURE <u>Thomas J. Solon</u> M.D.				PHYSICIAN'S NAME (Type) <u>Thomas Solon</u>				Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemty</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>				ADDRESS <u>Still Pond, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 19 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

#20. #

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4651
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>109 S. Queen Street</u>		d. STREET ADDRESS <u>109 S. Queen Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Elizabeth</u> Last <u>Starkey</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1879</u>
9. AGE (In years lost birthday) yrs. <u>81</u>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Centreville Q.A.Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wm. Thomas Battis</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Catherine Tarbutton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mary Elizabeth Starkey</u>		Address <u>109 S. Queen St. Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>William M. Gatewood</u> attended the deceased from <u>7/16/60</u> , 19____, to <u>7/29/60</u> , 19____, that I last saw the deceased alive on <u>4/25/60</u> , 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William M. Gatewood</u>		ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u>	
DATE SIGNED <u>5/1/60</u>			
PHYSICIAN'S NAME (Type) <u>William M. Gatewood</u>		<u>Chestertown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 2, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CLERGYMAN		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE		19. SIGNATURE OF INTERMENT PLACE		20. SIGNATURE OF OTHER			
JAMES EARL RAY		M		35		W		1928		MEMPHIS, TENN.		APR 4, 1968		MEMPHIS, TENN.		4:30 PM		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY			
FATHER		MOTHER		SISTER		BROTHER		GRANDFATHER		GRANDMOTHER		UNCLE		AUNT		Nephew		Niece		Other		Other		Other		Other		Other		Other		Other		Other		Other		Other			
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

1. NAME OF DECEASED
2. SEX
3. AGE
4. RACE
5. DATE OF BIRTH
6. PLACE OF BIRTH
7. DATE OF DEATH
8. PLACE OF DEATH
9. TIME OF DEATH
10. CAUSE OF DEATH
11. MANNER OF DEATH
12. SIGNATURE OF REGISTRAR
13. SIGNATURE OF DECEASED
14. SIGNATURE OF WITNESSES
15. SIGNATURE OF PHYSICIAN
16. SIGNATURE OF CLERGYMAN
17. SIGNATURE OF FUNERAL HOME
18. SIGNATURE OF BURIAL PLACE
19. SIGNATURE OF INTERMENT PLACE
20. SIGNATURE OF OTHER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
13M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
4652 Item 3 Film G264 6-8-60 et													
CERTIFICATE OF DEATH													
Reg. Dist. No.													
1. PLACE OF DEATH a. COUNTY Kent MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown					c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Anne's Hospital					d. STREET ADDRESS								
3. NAME OF DECEASED (Type or print) First Middle Last Way/a Pauline Thorpe					4. DATE OF DEATH Month Day Year April 30 19 60								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/16/1901		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Charles Robinson					14. MOTHER'S MAIDEN NAME Laura Wilson								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Dorothy Alexander (daughter)					Address	
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Rectum 154X DUE TO Pulmonary Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Metastases to the lung DUE TO from Carcinoma of Hepatic Flexure of Colon (Resected) (c)										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 4/23/60 to 4/30/60 , that I last saw the deceased alive on 4/30/60 , at 12 PM, from the causes and on the date stated above. and that death occurred at 9:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 5/1/60													
ACTUAL SIGNATURE Wm M. Raterwood M.D.					PHYSICIAN'S NAME (Type) Wm M. Raterwood								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					22b. DATE THEREOF 5/4/60		22c. NAME OF CEMETERY OR CREMATORY Millington Cemetery			22d. LOCATION (City, town, or county) (State) Millington, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows					ADDRESS Millington, Md.		24a. REC'D BY REGISTRAR DATE MAY 5 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Frank				

CERTIFICATE OF DEATH

Reg. Dist. No.

4653

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 3 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital		e. STREET ADDRESS 115 N. Queen Street	
3. NAME OF DECEASED (Type or print) First Johanna Middle Tollinger Last Wright		4. DATE OF DEATH Month 4 Day 2 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/83
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Kent County, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Noah Tollinger	
14. MOTHER'S MAIDEN NAME Mary Catherine Morris		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. none		INFORMANT Address John M. Wright, Son-Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystitis			INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-30 , 19 60 , to 4-2 , 19 60 , that I last saw the deceased alive on 4-2 , 19 60 , and that death occurred at 2:10 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 4-4-60			
ACTUAL SIGNATURE A.C. Dick		M.D. Chestertown, Md.	
PHYSICIAN'S NAME (Type) A.C. Dick			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/4/60	22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Marvin B. Williams		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE APR 5 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Fraws			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

AB-3

State of New York

County of ...

City of ...

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